

Screening Date: _____
Current Age: _____
1st screen _____ or Repeat _____
Parent/caregiver declined Nutrition Screening _____

Birth to 3 Nutrition Screening Tool

Child's Name: _____ Birthdate: Month _____ Day _____ Year _____

Parent/Caregiver: _____ Phone #: _____

Address: _____

Person completing screen: _____ Title: _____

Birth to 3 Agency: _____ Phone Number: _____

SECTION 1 - Medical Conditions

Please place a check by each of the following medical conditions for the child.

<input type="checkbox"/> Autism/PDD	<input type="checkbox"/> Cystic fibrosis	<input type="checkbox"/> Organ transplant
<input type="checkbox"/> Bronchopulmonary dysplasia (BPD)	<input type="checkbox"/> Down syndrome	<input type="checkbox"/> Prader-Willi Syndrome
<input type="checkbox"/> Cancer	<input type="checkbox"/> Failure to thrive	<input type="checkbox"/> Seizure disorder
<input type="checkbox"/> Cerebral palsy (CP)	<input type="checkbox"/> Fetal alcohol syndrome/ drug exposure	<input type="checkbox"/> Spina bifida
<input type="checkbox"/> Chromosomal/congenital disorder	<input type="checkbox"/> Lead exposure	<input type="checkbox"/> Technology dependent (i.e. trach, vent, etc.)
<input type="checkbox"/> Cleft lip and/or palate (unrepaired)	<input type="checkbox"/> Metabolic disorder (i.e. PKU, galactosemia, diabetes, etc.)	<input type="checkbox"/> Very low birthweight (1500g or less)
<input type="checkbox"/> Congenital heart defect		<input type="checkbox"/> > 6 weeks premature
<input type="checkbox"/> Other: _____		

SECTION 2 - Current Growth, Health and Feeding Concerns

Place a check by each of the concerns that either the child's doctor or parent/caregiver has for the child.

☐ Small for age ☐ Lack of weight gain ☐ Excess weight gain ☐ Weight loss ☐ Other: _____

Place a check by the following nutrition-related symptoms the child currently has that have lasted longer than 1 month.

☐ Constipation ☐ Poor appetite ☐ Diarrhea ☐ Vomits/reflux ☐ Use of a special formula or diet
☐ Tube feeding ☐ Other: _____

Place a check by each of the concerns the parent/caregiver or others has about the child's feeding/eating.

<input type="checkbox"/> Usually takes longer than 30 minutes to feed	<input type="checkbox"/> Formula-fed infant drinks less than 16 ounces in 24 hours (3-12 months)
<input type="checkbox"/> Difficult to feed	<input type="checkbox"/> Breast-fed infant nurses less than 6 times in 24 hours (birth-9 months)
<input type="checkbox"/> Gags or chokes often	<input type="checkbox"/> Refuses solid foods/certain textures (over 12 months)
<input type="checkbox"/> Eats non-food items	<input type="checkbox"/> Does not self-feed (over 15 months)
<input type="checkbox"/> Has difficulty sucking, swallowing, or chewing	<input type="checkbox"/> Needs bottle for most liquids (over 18 months)
<input type="checkbox"/> Feedings are stressful or upsetting for the child or parent/caregiver.	<input type="checkbox"/> Lack of food or infant formula in the household to meet child's needs
<input type="checkbox"/> Current unresolved food allergies/intolerances: _____	
<input type="checkbox"/> Other feeding/eating concerns for this child: _____	

Nutrition Assessment Referral/Service Coordination

If this child has a medical condition from SECTION 1 and one or more nutritional concerns checked in SECTION 2, OR if this child has two or more nutritional concerns in SECTION 2, it is recommended this child receive a nutrition assessment by a Registered Dietitian (RD).

Please check one of the following statements as indicated by the screening results from page one. Continue as instructed by the statement you check.

___ Meets criteria for nutrition assessment referral, continue below.

___ Does not meet criteria for nutrition assessment referral. Re-screen in 6 months or earlier as needed.

1. If this child is **currently seen by a RD**, enter the RD's name on line 1.
2. If this child is **not currently seen by a RD**, and a referral can be made through the primary care provider (PCP), enter the PCP's name on line 2.
3. If this child does not currently have a primary care provider, or the primary care provider is unable to arrange for a nutrition assessment by a RD, or a **direct referral to a Birth to 3 RD** is desired, enter the Birth to 3 RD's name on line 3.

1.	_____	
	<i>Current RD and Clinic name</i>	
or		
2.	_____	
	<i>PCP and Clinic name</i>	
or		
3.	_____	
	<i>Birth to 3 RD name</i>	

<i>Address</i>		

<i>Telephone</i>		<i>Email</i>

Parent/Caregiver Consent for Referral:

I, as my child's parent/caregiver give consent for the referral above. I understand this referral is for the purpose of arranging for my child to receive a nutrition assessment. I authorize communication between the Birth to 3 Program, Registered Dietitian and primary health care provider regarding my child's nutrition care. I understand that my consent is valid for one year from the date that I sign. I further understand that medical and Birth to 3 records may be shared among the Registered Dietitian, Primary Care Provider and Birth to 3 Program to coordinate my child's nutrition care.

X _____ Date: _____

If the child meets the criteria for a nutrition assessment referral and a referral is not made, please explain why:

___ Parent/caregiver not interested in nutrition assessment referral at this time.

___ Other: _____